IDAHO DEPARTMENT OF HEALTH & WELFARE

Division of Licensing & Certification

DDA/ResHab Certification - Statement of Deficiencies

Agency:	Back to Basic Living	**Region(s):**	5
Agency Type:	Res Hab	**Survey Dates:**	09/12/16-09/16/16
Certificate(s):	RHA-223	**Certificate(s) Granted:**	☒ 6 - Month Provisional ☐ 1 - Year Full ☐ 3 - Year Full

Rule Reference/Text	**Findings**	**Agency's Plan of Correction** **(Please refer to the Statement of Deficiencies cover letter for guidance)**	**Date to be Corrected** **(mm/dd/yyyy)**
16.04.17.101.04 101.CERTIFICATION - ISSUANCE OF CERTIFICATES. 04. Expiration of Certificate. An agency must request renewal of its certificate no less than ninety (90) days before the expiration of the certificate to ensure there is no lapse in certification. After initial certification the Department may issue a certificate that is in effect for up to three (3) years based upon an agency's substantial compliance with this chapter of rules. (3-29-12)	The agency lacks documentation the agency requested recertification.	1. Agency administrator will be aware of expiration date of certificate and notify the department 90 days prior to expiration of needed audit. 2. If a lapse has occurred Administrator will immedently contact the department immediately upon notice to ensure all services for participants are not jeopardized. 3. Agency Administrator will be responsible to ensure certificate has not lapsed. 4. A copy of certificate will be placed on Administrator's desk to refer to at all times. Administrator will include a review of certificate in a QA check monthly to coincide	*10/10/2016*

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		with monthly staff meeting to ensure compliance.	
16.04.17.202. 202.ADMINISTRATOR. An administrator is responsible and accountable for implementing the policies and procedures approved by the governing authority. (3-20-04)	The agency lacked evidence the administrator ensured implementation of the policies and procedures.	1. Agency Administrator will ensure all staff are aware of the agency policies, procedures and protocols are implemented and followed. 2. every employee will attend a policy and procedure orientation before working with the participants. Agency monthly staff meetings will include any changes made to policies and a reminder of relevant policies. If it is found that staff members are not following policies, they will be trained on those relevant policies and documentation will be placed in Personnel file. This is to ensure participants are receiving safe and effective services. 3. Agency Administrator or designee will ensure this is orientation and review is occurring and ongoing. 4. Upon hire each staff member will receive training in the areas and documentation placed in employee file. Each employee file will be reviewed and initialed by Agency Administrator or designee before working with participants. Administrator will monitor	*10/10/2016*

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		all policies each month to ensure they are in compliance with rule. This will be included in the monthly QA.	
16.04.17.202.03.b. 202.ADMINISTRATOR. 03. Responsibilities. The administrator, or his designee, must assume responsibility for: b. Developing and implementing policies and procedures for agency staff and provider training, quality assurance, evaluation, and supervision; (3-29-12)	The agency lacked evidence the administrator assumed responsibility for developing and implementing policies and procedures for agency staff training, quality assurance, evaluation and supervision.	1. Agency Administrator and/or designee will assume responsibility for development and implementation of all policy, procedure and protocols, 2. Staff training, quality assurance, evaluation and supervision will be monitored by QIDP, Administrator, Program Manager and Administrative Assistant. A quality Assurance check list will be placed in each employee file and reviewed quarterly for the length of employment. 3. Ongoing training will be conducted by one or more of the upper management during monthly staff meetings. A sign in sheet and meeting notes will be placed in the training binder for review by the department and documented on each employee training log in personnel file. 4. Periodic reviews by above personnel mentioned. Each of the upper management will monitor their designated responsibility	*1/10/2017*

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		and document review.	
16.04.17.203. 203.STAFF RESIDENTIAL HABILITATION PROVIDER TRAINING. Training must include orientation and ongoing training at a minimum as required under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 700 through 706. Training is to be a part of the orientation training and is required initially prior to accepting participants. All required training must be completed within six (6) months of employment with a residential habilitation agency and documented in the employee residential habilitation provider record. The agency must ensure that all employees and contractors receive orientation training in the following areas: (3-29-12)	Three of three employee record review lacked documentation the employee received orientation training prior to working with participants. For example: Employee 1's orientation training was not completed prior to working with participants. There is documentation of shadow shift work starting on 4/20/16 and orientation training dates are 4/29/16. Employee 2's orientation training was not completed prior to her working with participants. She started in homes on 11-16-15 and did not receive the orientation training until 11-24-15 Employee 3 did not receive the initial orientation training until about 20 days after going on shift in homes. He received shadow shift training by the house manager between 02/03/16 and 02/25/16 when he received training by the QIDP on 2/25/16.	1. All employees will receive orientation training prior to working with participants. Orientation of policies and QIPD training will be held at least one time a week. Employees will be required orientation training before contact with clients are made. 2. Quality assurance checks will be done on each employee to ensure all required documentation is present prior to shadowing and placed on the schedule This is to ensure that all training sited in IDAPA 16.04.17.203 is being addressed on each employee. 3. Administrator and or designee will initial and date each file contains proper documentation to ensure the scheduler is aware that each employee may be work with participants. 4. Quality assurance checks will be done on each employee to ensure all personnel is receiving orientation training prior to shadowing and placed on the schedule. This will be documented on training log in each employees file. No employee will be working with participants without a QA per	*10/1/16*

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	Repeat deficiency from 09/09/13 survey. **Also, see IDAPA 16.04.17.203.01-05**	Administrator.	
16.04.17.203.06. 203.STAFF RESIDENTIAL HABILITATION PROVIDER TRAINING. Training must include orientation and ongoing training at a minimum as required under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 700 through 706. Training is to be a part of the orientation training and is required initially prior to accepting participants. All required training must be completed within six (6) months of employment with a residential habilitation agency and documented in the employee residential habilitation provider record. The agency must ensure that all employees and contractors receive orientation training in the following areas: 06. First Aid and CPR. First aid, CPR, and universal precautions. (7-1-95)	One of three employee record review lacked documentation the received CPR/1st Aid certification prior to working with participants. For example: Employee 3's record lacked documentation he was CPR/1st Aid certified prior to working with participants. The employee started working in home on 2/3/16 but did not receive CPR/1st Aid training until 2/12/16. **Repeat Deficiency from10/15/15 complaint investigation and repeat deficiency from 09/09/13 survey.**	1. All employees will receive CPR training prior to working with participants. CPR/FA, Orientation of policies and QIPD training will be held at least one time a week. Employees will be required to have CPR/FA and orientation training before contact with clients are made. 2.Quality assurance checks will be done on each employee to ensure all required documentation is present prior to shadowing and placed on the schedule This is to identify participant safety and staff adequately trained to assist in an emergency. A list of upcoming CPR recertification will be kept by the Administrative assistance and Staff will be recertified before the CPR certification is expired.. 3. Administrator and or designee will initial and date each file contains proper documentation to ensure the scheduler is aware that each employee may be work with participants.	

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		4. Quality assurance checks will be done on each employee to ensure all required documentation is present prior to shadowing and placed on the schedule	
16.04.17.300. POLICY AND PROCEDURE MANUAL. A policy and procedure manual must be developed by the residential habilitation agency for effectively implementing its objectives. It must be approved by the governing authority. Policies and procedures must be reviewed annually and revised as necessary. The manual must, at a minimum, include policies and procedures reflecting the following: (3-20-04)	The agency lacks documentation the agency conducted an annual review of the policies and procedures for 2014, 2015, 2016. **Repeat deficiency from 09/09/13 survey.**	1. Agency Administrator will review Policies and procedures and protocols annually and revised as necessary. 2. Agency will place a quality assurance sheet in front of the policy book and initial at least every 6 months to ensure the information is in compliance with the Department. This is to ensure participants and staff members are safe and agency remains in compliance. 3. Administrator will be responsible to compare policies to required rules to ensure compliance. 4. By monitoring the IDAPA rule and reviewing the policy book every 6 months any need changes can be made	*10/30/2016*
16.04.17.301.03.j 301. PERSONNEL. 03. Personnel Records. A record for each	20 of 29 employee record review lacked verification the employee satisfactorily completed a criminal history check per rule	1. All employees will receive a CHC upon hire and a printed application will be notarized. Employees will be required to have, scheduled a fingerprint appointment	*Click here to enter a date.*

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employee must be maintained from date of hire for not less than one (1) year after the employee is no longer employed by the agency, and must include at least the following: j. Verification of satisfactory completion of criminal history checks in accordance with IDAPA 16.05.06, "Criminal History and Background Checks"; and (3-20-04)	requirements. For example: Employee 1's record lacked documentation of a local Idaho State Police (ISP) background check. The employee's date of hire was 04/20/16, the agency had documentation of a DHW clearance completed for another agency dated 11/06/14. Employee 5's record lacked documentation of a DHW clearance; the agency completed a local ISP only. The employee's date of hire was 11/02/15. Employee 6's record lacked documentation of a DHW or local ISP completion. The employee started working with participants on 04/30/16, the Self Dec. was completed 05/10/16 and cleared 05/19/16. Also, the DHW report does not list this clearance only a clearance for 08/13/13. Employee 7's record lacked documentation the agency completed the DHW clearance per rule requirements. The employee started working with participants 06/28/16 and the	(within 21 days) before contact with clients are made. Agency will require all employees to receive full CHC and will not except transfers or ISP reports. 2. Quality assurance checks will be done on each employee to ensure all required documentation is present prior to shadowing and placed on the schedule. This is to ensure that all participants are protected and staff are qualified to work with them. 3. Administrator and or designee will initial and date each file contains proper documentation to ensure the scheduler is aware that each employee may begin work with participants 4. Quality assurance checks will be done on each employee to ensure all required documentation is present prior to shadowing and placed on the schedule	

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	self dec. not completed until 07/19/16. The employee did not complete her fingerprints within the 21 days of the notarized self-declaration, not fingerprinted until 08/11/16. Employee 8's date of hire was 02/17/16. The agency completed the Self Dec. 03/10/16 approximately 21 days after the employee started working. Employee 9's start date with participants was 04/12/16, the agency has a copy of the DHW clearance for another agency dated 01/15/15 printed on 04/11/16 but not listed for the agency. The staff apparently printed the letter and gave to the agency. In addition, no documentation of an Idaho State Police Check (ISP). Employee 10's Self Dec. date was 07/21/16 and was not fingerprinted until 08/19/16 as the staff missed first appointment. The employee went over the 21 day timeline. Employee 11's date of hire was 03/08/16 and the self dec. was not completed until 04/07/16 and fingerprints not completed until 04/20/16. The employee worked for approximately 29 days prior to completing		

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	the self-dec. application. Employee 13's date of hire was 10/08/15, the self-dec. was completed 10/08/16 but the fingerprints were not completed for 23 days on 11/05/16. Not within 21 day rule requirement. Employee 15's self dec. was completed 05/19/19 and the fingerprints not completed until 06/16/16 approximately 26 days and does not meet CHC rule requirements. Employee 16's self-dec. was completed 05/17/16 and a fingerprint not completed until 06/30/16 approximately 43 days and does not meet CHC rule requirements. Employee 17's date of hire 12/28/15 and the agency completed a local Idaho State Police Check, but no documentation the employee was added to the agency's current DHW clearance if the employee has one. Employee 19's date of hire was 05/28/16, self-dec completed on 05/11/16 and missed fingerprint appointment on 05/28/16. No documentation this employee has cleared.		

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	Employee 21's date of hire was 10/22/15, the agency has a copy of the DHW clearance from another agency dated 07/06/09 on 10/28/15. The agency completed a local Idaho State Police check 11/03/15, but the DHW was over 3 years, not eligible to transfer and does not appear to be added to the agency's Criminal History number. Employee22's date of hire was 01/13/16, the self-dec. not completed until 04/19/16 and was fingerprinted on 05/06/16. The employee started working with participants on 01/13/16 and did not complete the self-dec. for approximately 3 months after the start date. Employee 23's started working with participants on 07/22/16. The self-dec was completed 07/29/16, missed a fingerprint appointment on 08/11/16 and the applicant status stated pending fingerprints-not available. Scheduled for next fingerprint appointment on 08/22/16, but not documentation of a DHW clearance. Employee 24's self-dec was completed approximately 2 months after the employee		

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	began working with participants. Employee 25's start date was 02/11/16, the self-dec was not completed until 04/05/16 approximately 2 months after the employee started working with participants. Employee 28's date of hire was 10/05/16 and his self-dec was completed 10/06/15 and the fingerprints were not completed until 29 days after the self-dec. on 11/06/15. Employee 29's date of hire was 01/18/16, the self-dec was not completed until 04/08/16 approximately 2 ½ months after the employee started working with participants. **Repeat deficiency from 12/05/13 investigation.**		
16.04.17.301.03.k. 301. PERSONNEL. 03. Personnel Records. A record for each employee must be maintained from date of hire for not less than one (1) year after the employee is no longer employed by the agency, and must include at least the	Two of five employee record review lack evidence the employee received a job description and understands his duties. For example: Employee 3 and 5's record lack evidence the employee received a job description and understands his duties.	1. All employees will receive job description training prior to working with participants. Job description and employee handbook will be held at least one time a week. Employees will be required to understand job description before contact with clients are made. 2. Quality assurance checks will be done on each employee to ensure all required	*Click here to enter a date.*

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following: k. Evidence that the employee has received a job description and understands his duties. (3-29-12)		documentation is present prior to shadowing and placed on the schedule. Direct Support Professionals will review Job description upon hire, during monthly staff meetings, evaluations and periodic QA checks with Field Mangers. This is to ensure that all employees are aware of what their job entails or any changes made after initial receipt of job description. 3. Administrator and or designee will initial and date each file contains proper documentation to ensure the scheduler is aware that each employee may be work with participants 4. Quality assurance checks will be done on each employee to ensure all required documentation is present prior to shadowing and placed on the schedule	
16.04.17.302.01.a 302.SERVICE PROVISION PROCEDURES. 01. Admission Procedures. The following criteria must apply to all participants receiving services from a residential	One of four participant record review lacked documentation of an agreement to serve each participant must be based on a recommendation of a person-centered planning process conducted by the participant's person-centered planning team, including his service coordinator.	1. The QIDP will go through participant 2's and each client's record and assure that an individual support plan was granted; that the TSC has provided the necessary follow up information that is needed for the plan development and that it is documented in the client's individual file.	*10/24/2016*

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habilitation agency: a. Agreement to serve each participant must be based on a recommendation of a person-centered planning process conducted by the participant's person-centered planning team, including his service coordinator. (3-20-04)	For example: Participant 2's record lacked documentation of an individual support plan.	The Quality Assurance staff personal will perform quarterly audits on each client's files to assure that the QIDP has completed, filed and documented all necessary parts of the client's program. The QIDP will create and follow a check list of the plan process to assure that each stage of the process from the TSC meeting to the implementation plan has been followed and completed. A copy of this checklist is provided, and will be used by both the QIDP and quality assurance. 2.The QIDP will go through each client's record and assure that an individual support plan was granted; that the TSC has provided the necessary follow up information that is needed for the plan development and that it is documented in the client's individual file. Corrective measures will be to correct the deficit assuring that an updated implementation plan of the client is in the client's individual file. 3.The QIDP will be responsible to correct any lack or missing information concerning the implementation plans. The quality assurance will be responsible	

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		for assuring that the QIDP is performing their duties. The administrator or designee will conduct quarterly review to ensure compliance with 16.04.17.302.01.a 4. The QIDP utilizing the checklist created to prevent such deficits in the future. The quality assurance auditing the individual client's files. 5. Corrective actions will begin on Monday October 17, 2016 and be completed by Monday October 24, 2016.	
16.04.17.302.01.b. 302.SERVICE PROVISION PROCEDURES. 01. Admission Procedures. The following criteria must apply to all participants receiving services from a residential habilitation agency: b. The agency must obtain authorization from the Department for reimbursement for each Medicaid-covered eligible waiver service prior to providing residential habilitation services in accordance with IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 507 through 515 (3-20-04)	Two of four participant record review lacked documentation of an authorized Individual Support Plan. For example: Participant 2's record lacked documentation of an authorized Individual Support Plan. Participant 4's record lacked documentation of an authorized plan or extension after 08/18/16.	1. The QIDP will go through each client's record and assure that an individual support plan was authorized and that if applicable an extension is authorized and in file; that the TSC has provided the necessary follow up information that is needed for the plan development and that it is documented in the client's individual file. The Quality Assurance staff personal will perform quarterly audits on each client's files to assure that the QIDP has completed, filed and documented all necessary parts of the client's program. The QIDP will document in the appropriate place in the individual client's file that an	*10/24/2016*

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		extension is in the process and utilize the checklist to assure that this is provided. The QIDP will create and follow a check list of the plan process to assure that each stage of the process from the TSC meeting to the implementation plan has been followed and completed. A copy of this checklist is provided, and will be used by both the QIDP and quality assurance. 2. The QIDP will go through each client's record and assure that an individual support plan was granted and an extension if applicable is granted and filed; that the TSC has provided the necessary follow up information that is needed for the plan approval and if not proof of an extension and that it is documented in the client's individual file. The Quality Assurance staff personal will perform quarterly audits on each client's files to assure that the QIDP has completed, filed and documented all necessary parts of the client's program. The QIDP will create and follow a check list of the plan process to assure that each stage of the process from the TSC meeting to the implementation plan has been	

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		followed and completed. A copy of this checklist is provided, and will be used by both the QIDP and quality assurance. Corrective measures will be to correct the deficit assuring that an updated plan approvals or extensions of the client is in the client's individual file. 3. The QIDP will be responsible to correct any lack or missing information concerning the approvals or extensions of implementation plans. The quality assurance will be responsible for assuring that the QIDP is performing their duties. The administrator or designee will conduct quarterly review to ensure compliance with 16.04.17.302.01.b 4. The QIDP utilizing the checklist created to prevent such deficits in the future. The quality assurance auditing the individual client's files. 5. Corrective actions will begin on Monday October 17, 2016 and be completed by Monday October 24, 2016.	
16.04.17.302.02. 302.SERVICE PROVISION PROCEDURES.	One of four participant record review lacked documentation each participant must have	1. The QIDP will review participant 1's specific goals and objectives that coincide to	*10/24/2016*

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02. Implementation Plan. Each participant must have an implementation plan that includes goals and objectives specific to his plan of service residential habilitation program. (3-20-04)	an implementation plan that includes goals and objectives specific to his plan of service residential habilitation program. For example: Participant 1's implementation plans lacked 3 programs authorized on the plan of services, household chores, deal w/voices in her head, reduce the time she obsesses, access community.	the plan of services residential habilitation program and make any corrections that are needed to comply to the client's plan with the participants TSC. The QIDP will review all agency participant's specific goals and objectives that coincide to the plan of services residential habilitation program and make any corrections that are needed to comply to the client's plan. The QIDP created a form that will be used to assess and address any changes in the client's goal needs throughout the client's yearly plan. Form will be included. 2. The QIDP will review all client's files and assure that the specific goals and objectives correlate to the plan of services in their residential habilitation program, and make any corrections that are needed to assure that compliance is made to the client's plan as made with the client and the client's TSC.The Quality Assurance staff personal will perform quarterly audits on each client's files to assure that the QIDP has completed, filed and documented all necessary parts of the client's program.The QIDP will follow the form created by the QIDP to asses and	

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		review the client's needs regarding the client's goals and during routine contact with the client and the client's TSC communicate any changes to the goals are reviewed and addressed. If any goal or change of the client's need is determined by Back to Basic staff, such as a goal is no longer needed, or needs to be added or adjusted; the proper documentation will be made and sent to the client's TSC for approval. Documentation of the change will be entered and recorded in the clients individual file. 3. The QIDP will be responsible to correct any lack or missing information concerning the approvals or extensions of implementation plans. The quality assurance will be responsible for assuring that the QIDP is performing their duties. The administrator or designee will conduct quarterly review to ensure compliance with 16.04.17.302.02. 4. The QIDP utilizing the checklist created to prevent such deficits in the future. The quality assurance auditing the individual client's files.	

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		5. Corrective actions will begin on Monday October 17, 2016 and be completed by Monday October 24, 2016.	
16.04.17.302.04. 302.SERVICE PROVISION PROCEDURES. 04. Medication Standards. The agency must maintain a policy describing the program's system for handling participant medications which is in compliance with the IDAPA 23.01.01, "Rules of the Board of Nursing." (3-20-04)	Three of four participant record review lacked documentation the agency followed its policy describing the program's system for handling participant medications which is in compliance with the IDAPA 23.01.01 Nursing rules. For example: Participant 2, 3 and 4's record lacked documentation of PRN prescriptions on the med. Sheet and the over the counter PRN medications not listed in the home. Participant 2's Cough medicine and Inhaler were not listed on the MARS. The over the counter meds and creams not listed in the binder at the home. Participant 3's Medication (valium) given to calm down for dental exam but no prescription found and not listed on the MARS. Documented by staff on a PRN log. Participant 4's MARS were missing staff	1. All Clients of Back to Basics will have the exact color of capsule or pill in bubble pack and right mgs on Mars, also any prescription drug or over the counter as PRN to be put on Mars sheet. No medication is to be given to any client unless ordered or allowed by physician. If a guardian brings any medication in to participant prescription or OTC the staff is to call Program manager immediately so the correct documentation is made to mars and participant file. 2. Program Manager will make sure a prescription is in house to follow with PRN Meds to go on Mars. 3. Agency Nurse, and Program Manager will assure staff will get proper instructions. Only Medication Certified employees will be allowed to pass any medication. When a participant leaves their home for a visit or stay and no Back to Basic Staff is with them. The staff are to write LOA as stated in medication	*10-24--2016*

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	initials on med log. (Sep 9 & 11). MARS white pill but bubble pack is pink pill. Not clear documentation regarding the meds that he is taking to his parents' house when he visits on the weekends. Fish oil administered regularly for pain/headaches but none in his med. container at the home. Also see IDAPA 16.04.17.400.02.m **Repeat deficiency from 10/15/15 investigation.**	protocol. 4. Program Manager will monitor each participant's medication and create a mars with all medication taken by participant listed. The Agency nurse will be informed of all needed updates or changes.	
16.04.17.302.05. 302.SERVICE PROVISION PROCEDURES. 05. Provider Status Review. Residential Habilitation agencies must submit semiannual and annual status reviews reflecting the status of behavioral objectives or services identified on the plan of service to the plan monitor. Semiannual status reviews must remain in participant file and annual status reviews must be attached to annual plan of service. (3-20-04)	Three of four participant record review lacked documentation the agency completed semi annual and annual status review reflecting the status of behavioral objectives or services identified on the plan of service to the plan monitor. For example: Participant 2's record lacked documentation of a Provider Status Review for Plan year 06/26/15-06/25/16. Participant 3's record lacked documentation of a Provider Status Review for plan year 2015-2016 and 2014-2015. The most recent Status review was completed 04/08/13.	1. The QIDP will go through each client's record and assure that an individual support plan and Provider Status reviews are in place and was communicated with TSC. Any necessary follow up information that is needed for the plan development and that it is documented in the client's individual file. The QIDP will document in the appropriate place in the individual client's file and utilize the checklist to assure that this is provided. The QIDP will create and follow a check list of the plan process to assure that each stage of the process from the TSC meeting to the implementation plan has been followed and completed. A copy of this checklist is provided, and will be used by	*10/24/2016*

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	Participant 4's record lacked documentation of a Provider Status Review for current plan, due 08/16. Also, no documentation submitted to the Plan Monitor.	both the QIDP, Administrator and designee 2.The QIDP will go through each client's record and assure that an individual support plan and Provider Status reviews are in place and was communicated with TSC. Any necessary follow up information that is needed for the plan development and that it is documented in the client's individual file. The Quality Assurance staff personal will perform quarterly audits on each client's files to assure that the QIDP has completed, filed and documented all necessary parts of the client's program. Corrective measures will be to correct the deficit assuring that an updated plan approvals or extensions of the client is in the client's individual file. 3. The QIDP will be responsible to correct any lack or missing information concerning the approvals or extensions of implementation plans. The quality assurance will be responsible for assuring that the QIDP is performing their duties. The administrator or designee will QA each participant file quarterly to ensure compliance with IDAPA 16.04.17.302.05.	

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		4. The QIDP utilizing the checklist created to prevent such deficits in the future.The quality assurance auditing the individual client's files. 5. Corrective actions will begin on Monday October 17, 2016 and be completed by Monday October 24, 2016.	
16.04.17.400.02.f. 400.PARTICIPANT RECORDS. 02. Required Information. Records must include at least the following information: f. Physician, dentist, and other health care providers. (7-1-95)	Two of four participant record review lacked documentation the record included physician, dentist and other health care providers. For example: Participant 1 and 4's record lacked documentation of a dentist.	1. The QIDP will go through each client's record and assure that all participants have all health care providers documented. Any necessary changes will be documented in the client's individual file. The Quality Assurance staff personal will perform quarterly audits on each client's files to assure that the QIDP has completed, filed and documented all necessary parts of the client's record. 2. The QIDP will review all client's records and ensure all health related providers are updated and documented The Administrator and designee will perform quarterly audits on each client's files to assure that the QIDP has completed, filed and documented all necessary parts of the client's record. 3. QIDP, Program Manager Administrator and designee will communicate when health care related providers need	*10-30-2016*

Rule Reference/Text	Findings	Agency's Plan of Correction (Please refer to the Statement of Deficiencies cover letter for guidance)	Date to be Corrected (mm/dd/yyyy)
		updated or changed. 4. The Administrator and designee will perform quarterly audits on each client's files to assure that the QIDP has completed, filed and documented all necessary parts of the client's record.	
16.04.17.400.02.o. 400.PARTICIPANT RECORDS. 02. Required Information. Records must include at least the following information: o. The plan of service including implementation plans maintained by the agency and data-based progress notes. (3-20-04)	One of four participant record review lacked documentation the plan of service including implementation plans maintained by the agency and data-based progress notes. For example: Participant 2's record lacked documentation of an Individual Service Plan.	1.The QIDP will review all agency participant's specific goals and objectives that coincide to the plan of services residential habilitation program and make any corrections that are needed to comply to the client's plan with the participants TSC.The QIDP created a form that will be used to assess and address any changes in the client's goal needs throughout the client's yearly plan. Form will be included. 2. The QIDP will review all client's files and assure that the specific goals and objectives correlate to the plan of services in their residential habilitation program, and make any corrections that are needed to assure that compliance is made to the client's plan as made with the client and the client's TSE. The Quality Assurance staff personal will perform quarterly audits on each client's files to assure that the QIDP has completed, filed and documented all necessary parts of the client's program. 3. The QIDP will be responsible to correct	10/24/2016

Rule Reference/Text	Findings	Agency's Plan of Correction (Please refer to the Statement of Deficiencies cover letter for guidance)	Date to be Corrected (mm/dd/yyyy)
		any lack or missing information concerning the approvals or extensions of implementation plans. The quality assurance will be responsible for assuring that the QIDP is performing their duties. The administrator or designee will conduct quarterly audits to ensure compliance with IDAPA 16.04.17.400.02.o. 4. The QIDP utilizing the checklist created to prevent such deficits in the future. The quality assurance auditing the individual client's files. 5. Corrective actions will begin on Monday October 17, 2016 and be completed by Monday October 24, 2016.	

Agency Representative & Title: Karen Smith, Administrator * By entering my name and title, I approve of this plan of correction as it is written on the date identified.	**Date Submitted:** 10/12/2016
Department Representative & Title: Pam Loveland-Schmidt, L&C * By entering my name and title, I approve of this plan of correction as it is written on the date identified.	**Date Approved:** 10/21/2016